ATTACHMENTS

ATTACHMENT 1
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

129 - Child/Adolescent Mental Health Day Treatment and In-Home Treatment Services (not AODA Day Treatment)

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number from the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, first name, and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), from the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the billing provider's name and complete address (street, city, state, and zip code). ***No other information should be entered in this element since it also serves as a return mailing label.***

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the billing provider's eight-digit Medical Assistance provider number.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (Not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (Not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate procedure code for each service requested, in this element.

ELEMENT 15 - MODIFIER (Not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service would be provided.

Day Treatment		In-Home Treatment	
Code	**Description**	**Code**	**Description**
2	Outpatient Hospital	0*	Other
3	Office	4	Home

* Use place of service "0" when requesting prior authorization for travel time.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service requested.

Numeric	Description
1	In-Home Treatment
9	Child/Adolescent Day Treatment

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the number of services requested.

Child/Adolescent Day Treatment (number of hours)
In-Home Treatment (number of hours)

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Social Services's Terms of Provider Reimbursement.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement is only allowed if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER – THIS SPACE IS USED BY THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).